SOUTHERN CALIFORNIA SLEEP DISORDERS SPECIALISTS **SLEEP/WAKE QUESTIONNAIRE**

Name _____ Date _____

Age _____ Who referred you to the Sleep Center? _____

1) My main sleep complaint is: (number all that apply, with #1 being the biggest issue)
   _____ trouble falling to sleep at night
   _____ trouble staying asleep at night
   _____ being sleepy during the daytime
   _____ snoring
   _____ unwanted behavior during sleep (explain) _____
   _____
   _____ other (explain) _____
   _____
2) How long have you had this problem? _____
3) What position do you prefer to sleep in? _____
4) A) What is your normal bed time? _____ B) Normal wake time? _____
5) Please use a check (✓) to mark any statement which applies to you:

   _____ unrefreshing naps
   _____ refreshing naps
   _____ very loud snorer
   _____ restless sleeper
   _____ awaken with a choking sensation
   _____ stop breathing during sleep
   _____ awaken with headaches
   _____ difficulty waking in the morning
   _____ gained more than 10 lbs. in the last year
   _____ fall asleep at inappropriate times
   _____ dream a lot
   _____ dream or hallucinate while awake
   _____ paralysis or inability to move upon awakening
   _____ sudden sensation of weakness in knees or legs
   _____ general body weakness
   _____ driven miles past destination with little awareness
   _____ kicking or twitching during sleep
   _____ legs jerk during sleep
   _____ experience restlessness or tingling sensation in legs
   _____ experience inability to keep legs still
   _____ trouble falling asleep
   _____ trouble returning to sleep
   _____ awaken long before necessary
   _____ sleep better in unfamiliar settings
   _____ use sleeping pills
   _____ grind teeth in sleep
   _____ jaws ache upon awakening
   _____ sleepwalking as an adult
   _____ sleepwalking as a child
   _____ bedwetting as an adult
   _____ sudden awakening with intense dread or anxiety
   _____ shift worker or night worker
   _____ late sleeper
   _____ bitter or sour mouth taste upon awakening
   _____ bitten tongue during sleep
   _____ awaken with heartburn

6) How likely are you to **DOZE** or **FALL ASLEEP** in the following situations, in contrast to feeling just tired? This refers to your usual way of life in **RECENT TIMES.** Even if you have not done some of these things recently, try to work out how they would have affect to the following:

(Use the following scale to choose the most appropriate number for each situation)

0 = would **never** doze
1 = **slight** chance of dozing
2 = **moderate** chance of dozing
3 = **high** chance of dozing

SITUATION	**CHANCE OF DOZING**
Sitting and reading.	_____
Watching TV.	_____
Sitting, inactive in a public place. (Example; a theater or a meeting)	_____
As a passenger in a car for an hour without a break.	_____
Lying down to rest in the afternoon when circumstances permit.	_____
Sitting and talking to someone.	_____
Sitting quietly, after a lunch without alcohol.	_____
In a car, while stopped for a few minutes in traffic.	_____
TOTAL FROM ABOVE	_____

The following refer to YOUR medical history: (please place a check (✓) next to any items which YOU have had)

____ Seizures or epilepsy
____ Parkinson's Disease
____ Concussion or head trauma
____ Heart attack
____ Angina, chest pain
____ Arrhythmia (palpitations)
____ Thyroid problems
____ Drug or alcohol addiction
____ Loss of consciousness
____ Diabetes
____ Heart failure
____ Asthma
____ Emphysema, lung disease
____ High blood pressure
____ Allergies

Prescription and non-Prescription Medications:

medication	for what	dosage
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____